EXHIBIT "A"

Case 1:14-cv-00140-MRH Document 51-1 Filed 06/30/16 Page 2 of 9

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CLAIM FOR DAMAGE, INJURY, OR DEATH	INSTRUCTIONS: Please read carefully the instructions on the reverse side and supply information requested on both sides of this form. Use additional sheet(s) if necessary. See reverse side for additional instructions.	FORM APPROVED OMB NO. 1105-0008

1. Submit To Appropriate Federal Agency:
DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF REGIONAL COUNSEL
VA PITTSBURGH HEALTH CARE SYSTEM
~~[illegible]~~ 1010 Delafield Road ~~[illegible]~~
PITTSBURGH, PA ~~[illegible]~~ 15215

2. Name, Address of claimant and claimant's personal representative, if any. (See instructions on reverse.) (Number, Street, City, State and Zip Code)
THEDE MOHR HIGHHOUSE
9091 Leet Road
North East, PA 16428

3. TYPE OF EMPLOYMENT	4. DATE OF BIRTH	5. MARITAL STATUS	6. DATE AND DAY OF ACCIDENT	7. TIME (A.M. OR P.M.)
X MILITARY ☐ CIVILIAN	[redacted]	Separated	2/4/11 through & continuing to 1/30/12 – Date of discovery	

8. Basis of Claim (State in detail the known facts and circumstances attending the damage, injury, or death, identifying persons and property involved, the place of occurrence and the cause thereof. Use additional pages if necessary.)

Claimant, Thede Morh Highhouse was injured in a skiing accident, where he fell and twisted his left wrist. On January 22, 2011, claimant presented to ER of Erie VAMC and was seen by ER doctor, Dr. Clayton Lindemuth. Claimant suffered a wrist fracture which was reduced by Dr. Michael Fitzgerald. Claimant also hit his head in the accident, so Dr. Lindemuth ordered a Head CT on January 22, 2011. Due to an abnormality on the CT, Dr. Lobell (the reading physician) recommended an MRA of the brain for further characterization. On Claimant's follow up visit of January 24, 2011 with Dr. Michael Fitzgerald, Claimant was instructed to make a follow up appt. with his primary clinic as follow up to his abnormal CT of his head--Lydia J. Maring, CRNP signed off on the above note. Claimant's primary care provider was Lydia J. Maring, CRNP. On January 24, 2011, Lydia J. Maring, CRNP ordered an MRA of claimant's head at Saint Vincent Health Center for further evaluation of his CT scan, and told him to come for an increase in headache. Claimant's headaches decreased and in

9. PROPERTY DAMAGE

NAME AND ADDRESS OF OWNER, IF OTHER THAN CLAIMANT (Number, Street, City, State, and Zip Code).
N/A

BRIEFLY DESCRIBE THE PROPERTY, NATURE AND EXTENT OF DAMAGE AND THE LOCATION WHERE PROPERTY MAY BE INSPECTED. (See instructions on reverse side.)
N/A

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10. PERSONAL INJURY/WRONGFUL DEATH

STATE NATURE AND EXTENT OF EACH INJURY OR CAUSE OF DEATH, WHICH FORMS THE BASIS OF THE CLAIM. IF OTHER THAN CLAIMANT, STATE NAME OF INJURED PERSON OR DECEDENT.

Injuries include, but are not limited to, growth in size of basilar tip aneurysm, ruptured basilar tip aneurysm, extensive subarachnoid hemorrhage as a result of the ruptured basilar tip aneurysm, nausea, vomiting, GI upset, weakness, fever, cerebral salt wasting syndrome, hyponatremia requiring salt supplementation, atrial fibrillation, atrial flutter, heart injury and problems, massive thunderclap quality headaches, numbness in both legs, burning eyes, dizziness, vertigo, short term memory loss, hearing loss, ringing and noise in ears, vision loss, double vision, lower quadrant visual obscuration, blurriness with kaleidoscope or prism patterns of disturbance, ocular migraines with temporal swelling, loss of coordination, weakness in hands, knees and legs, loss of bladder control (CONT'D)

11. WITNESSES

NAME	ADDRESS (Number, Street, City, State, and Zip Code)
1. Thede M. Highhouse	9091 Leet Road, North East, PA 16428
2. Dana Lewis	18 Buckhead Lane, Simpsonville, SC 29681
3. Tom Highhouse	8428 44th Street-North, Pinellas Place, FL 33781
4. Marjorie Beck	3809 Draper Place, Erie, PA 16511

WITNESS LIST CONTINUED ON NEXT PAGE

12. (See instructions on reverse.) AMOUNT OF CLAIM (in dollars)

12a. PROPERTY DAMAGE	12b. PERSONAL INJURY	12c. WRONGFUL DEATH	12d. TOTAL (Failure to specify may cause forfeiture of your rights.)
N/A	$2,000,000.00	N/A	$2,000,000.00

I CERTIFY THAT THE AMOUNT OF CLAIM COVERS ONLY DAMAGES AND INJURIES CAUSED BY THE INCIDENT ABOVE AND AGREE TO ACCEPT SAID AMOUNT IN FULL SATISFACTION AND FINAL SETTLEMENT OF THIS CLAIM

13a. SIGNATURE OF CLAIMANT (See instructions on reverse side.)	13b. Phone number of person signing form	14. DATE OF SIGNATURE
[signature] Christa Stacy, Esq. PA ID: 86841 Ohio ID: 0068434	(814-464-5725) 814-454-4540	4/25/2013

CIVIL PENALTY FOR PRESENTING FRAUDULENT CLAIM	CRIMINAL PENALTY FOR PRESENTING FRAUDULENT CLAIM OR MAKING FALSE STATEMENTS
The claimant is liable to the United States Government for the civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages sustained by the Government. (See 31 U.S.C. 3729.)	Fine, imprisonment, or both. (See 18 U.S.C. 287, 1001.)

95-109 NSN 7540-00-634-4046 STANDARD FORM 95 PRESCRIBED BY DEPT. OF JUSTICE 28 CFR 14.2

RECEIVED MAY 02 2013 BY: [initials]

2891

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PAGE 2 of 8

CLAIM FOR DAMAGE, INJURY, OR DEATH	INSTRUCTIONS: Please read carefully the instructions on the reverse side and supply information requested on both sides of this form. Use additional sheet(s) if necessary. See reverse side for additional instructions.	FORM APPROVED OMB NO. 1105-0008

1. Submit To Appropriate Federal Agency:	2. Name, Address of claimant and claimant's personal representative, if any. (See instructions on reverse.) (Number, Street, City, State and Zip Code)
DEPARTMENT OF VETERANS AFFAIRS OFFICE OF REGIONAL COUNSEL VA PITTSBURGH HEALTH CARE SYSTEM ~~[illegible]~~ 1010 Delafield Road PITTSBURGH, PA ~~15206-1297~~ 15215	THEDE MOHR HIGHHOUSE 9091 Leet Road North East, PA 16428

3. TYPE OF EMPLOYMENT	4. DATE OF BIRTH	5. MARITAL STATUS	6. DATE AND DAY OF ACCIDENT	7. TIME (A.M. OR P.M.)
X MILITARY ☐ CIVILIAN	8/23/55	Separated	2/4/11 through & continuing to 1/30/12	

8. Basis of Claim (State in detail the known facts and circumstances attending the damage, injury, or death, identifying persons and property involved, the place of occurrence and the cause thereof. Use additional pages if necessary.)

(CONT'D):a phone call on January 27, 2011, he was still told by nurse Malinowski to keep his appointment with SVHC for his MRA per Maring's instructions. On February 4, 2011, Claimant underwent an MR Angiogram of the Head w/o contrast and MR of the brain w/o contrast as ordered by his PCP Lydia J. Maring, CRNP. The results were never shared with Claimant by any agent or employee of the VAMC but revealed a "rather large basilar tip aneurysm and possible communicating artery aneurysm". The study was completed at or around 1:17 p.m. and around 2:18 p.m., the same day, on February 4, 2011, Lydia J. Maring, CRNP prescribed Hydrocodone and Acetaminophen for Claimant but did nothing in response to the abnormal MRA/MRI results. On March 24, 2011, Claimant followed up with Lydia J. Maring, CRNP, an agent, servant and/or employee of the VAMC. Lydia J. Maring, CRNP was negligent in several respects: Lydia J. Maring, CRNP NEVER followed up on the MRA/MRI of 2/4/11 and NEVER advised Claimant that he had a basilar tip aneurysm or communicating artery

9. PROPERTY DAMAGE

NAME AND ADDRESS OF OWNER, IF OTHER THAN CLAIMANT (Number, Street, City, State, and Zip Code).

BRIEFLY DESCRIBE THE PROPERTY, NATURE AND EXTENT OF DAMAGE AND THE LOCATION WHERE PROPERTY MAY BE INSPECTED. (See instructions on reverse side.)

10. PERSONAL INJURY/WRONGFUL DEATH

STATE NATURE AND EXTENT OF EACH INJURY OR CAUSE OF DEATH, WHICH FORMS THE BASIS OF THE CLAIM. IF OTHER THAN CLAIMANT, STATE NAME OF INJURED PERSON OR DECEDENT.

(CONT'D):acute urinary retention, back pain, back spasms, neck pain, anxiety, depression, trouble walking, necessity to use a cane as an assistive device, inability to work due to memory loss and dizziness after the rupture of his aneurysm, untreated aneurysm at the anterior communicating artery complex level, which required separate treatment with separate surgery and convalescence in the face of a previous coil embolization, residual aneurysm lumen, recurrence and recanalization of basilar tip aneurysm, increased risk for recanalization of the basilar tip aneurysm due to its rupture, increased risk for recanalization of the anterior communicating artery, arm numbness and discomfort, severe insomnia, severe emotional distress, and all symptoms and sequelae associated with all

11. WITNESSES

NAME	ADDRESS (Number, Street, City, State, and Zip Code)
(CONT'D): 5. Cheryl A. Russ, M.D.	Veterans Affairs Medical Center, Erie, PA
6. Charles E. Romero, M.D.	Saint Vincent Neurointervention, 1910 Sassafras Street, Suite 300, Erie, PA 16502
7. Anthony P. Behm, D.O.	Veterans Affairs Medical Center, Erie, PA
8. Jaydutt B. Patel, M.D.	Saint Vincent Consultants in Cardiology, 2315 Myrtle Street, Suite 190, Erie, PA 16502

12. (See instructions on reverse.) AMOUNT OF CLAIM (in dollars)

12a. PROPERTY DAMAGE	12b. PERSONAL INJURY	12c. WRONGFUL DEATH	12d. TOTAL (Failure to specify may cause forfeiture of your rights.)
N/A	$2,000,000.00	N/A	$2,000,000.00

I CERTIFY THAT THE AMOUNT OF CLAIM COVERS ONLY DAMAGES AND INJURIES CAUSED BY THE INCIDENT ABOVE AND AGREE TO ACCEPT SAID AMOUNT IN FULL SATISFACTION AND FINAL SETTLEMENT OF THIS CLAIM

13a. SIGNATURE OF CLAIMANT (See instructions on reverse side.)	13b. Phone number of person signing form	14. DATE OF SIGNATURE
[signature] [signature], Esq. PA ID: 86841 Ohio ID: 0063434	(814)4645745) (814)451-1510	4/25/2013

CIVIL PENALTY FOR PRESENTING FRAUDULENT CLAIM	CRIMINAL PENALTY FOR PRESENTING FRAUDULENT CLAIM OR MAKING FALSE STATEMENTS
The claimant is liable to the United States Government for the civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages sustained by the Government. (See 31 U.S.C. 3729.)	Fine, imprisonment, or both. (See 18 U.S.C. 287, 1001.)

95-109 NSN 7540-00-634-4046 STANDARD FORM 95
PRESCRIBED BY DEPT. OF JUSTICE
28 CFR 14.2

MAY 0 1 2013

BY: [signature]

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CLAIM FOR DAMAGE, INJURY, OR DEATH	INSTRUCTIONS: Please read carefully the instructions on the reverse side and supply information requested on both sides of this form. Use additional sheet(s) if necessary. See reverse side for additional instructions.	FORM APPROVED OMB NO. 1105-0008

1. Submit To Appropriate Federal Agency:	2. Name, Address of claimant and claimant's personal representative, if any. (See instructions on reverse.) (Number, Street, City, State and Zip Code)
DEPARTMENT OF VETERANS AFFAIRS OFFICE OF REGIONAL COUNSEL VA PITTSBURGH HEALTH CARE SYSTEM ~~7180 HIGHLAND DRIVE (646/82-11)~~ 1010 Delafield Road ~~(646/82-11)~~ PITTSBURGH, PA ~~15206-4297~~ 15215	THEDE MOHR HIGHHOUSE 9091 Leet Road North East, PA 16428

3. TYPE OF EMPLOYMENT	4. DATE OF BIRTH	5. MARITAL STATUS	6. DATE AND DAY OF ACCIDENT	7. TIME (A.M. OR P.M.)
☒ MILITARY ☐ CIVILIAN	8/23/55	Separated	2/4/11 through & continuing to 1/30/12	

8. Basis of Claim (State in detail the known facts and circumstances attending the damage, injury, or death, identifying persons and property involved, the place of occurrence and the cause thereof. Use additional pages if necessary.)

(CONT'D):aneurysm, and she did NOTHING to address the two aneurysms found from the MRA/MRI test study she ordered, she never referred the claimant to a neurologist or surgeon for treatment and consultation. On October 20, 2011, Claimant presented for an access appt. to the VAMC and was seen by David M. Lavin, M.D., an agent, servant and/or employee of the VAMC and he also failed to review the claimant's chart and follow up on the results of the MRA/MRI of 2/4/11, and he also did nothing in response to the claimant's basilar tip aneurysm or communicating artery aneurysm, and he failed to refer Claimant for treatment of same. On October 26, 2011, Claimant requested to see his PCP for jaw pain he had been having and also for follow-up since being placed on antibiotics and also for his routine follow up, but Lydia Maring, CRNP did not see him in the clinic since it was after 12 p.m., even though he was due for routine follow-up. Still, she did NOTHING to address the two aneurysms found from the test study she ordered.

9. PROPERTY DAMAGE

NAME AND ADDRESS OF OWNER, IF OTHER THAN CLAIMANT (Number, Street, City, State, and Zip Code).

BRIEFLY DESCRIBE THE PROPERTY, NATURE AND EXTENT OF DAMAGE AND THE LOCATION WHERE PROPERTY MAY BE INSPECTED. (See instructions on reverse side.)

10. PERSONAL INJURY/WRONGFUL DEATH

STATE NATURE AND EXTENT OF EACH INJURY OR CAUSE OF DEATH, WHICH FORMS THE BASIS OF THE CLAIM. IF OTHER THAN CLAIMANT, STATE NAME OF INJURED PERSON OR DECEDENT.

(CONT'D): of the above diagnoses, severe pain and suffering, avoidable medical treatment and enormous medical expenses, including several hospitalizations, procedures and future treatment continuing into the indefinite future from permanent damage caused by the negligence of VA Medical Ctr.-Erie employees/agents. The damages above are not exhaustive.

11. WITNESSES

NAME	ADDRESS (Number, Street, City, State, and Zip Code)
(CONT'D): 9. Wei Lung Sam Wu, M.D. 10. Lydia J. Maring, CRNP	Associates in Nephrology, P.C. 311 West 24th Street, Erie, PA 16502 Veterans Affairs Medical Center, Erie, PA

12. (See instructions on reverse.) AMOUNT OF CLAIM (in dollars)

12a. PROPERTY DAMAGE	12b. PERSONAL INJURY	12c. WRONGFUL DEATH	12d. TOTAL (Failure to specify may cause forfeiture of your rights.)
N/A	$2,000,000.00	N/A	$2,000,000.00

I CERTIFY THAT THE AMOUNT OF CLAIM COVERS ONLY DAMAGES AND INJURIES CAUSED BY THE INCIDENT ABOVE AND AGREE TO ACCEPT SAID AMOUNT IN FULL SATISFACTION AND FINAL SETTLEMENT OF THIS CLAIM

13a. SIGNATURE OF CLAIMANT (See instructions on reverse side.)	13b. Phone number of person signing form	14. DATE OF SIGNATURE
PA ID# 86841 Ohio ID# 0060434	(814) 4645926 (814) 454-4540	4/25/2013

CIVIL PENALTY FOR PRESENTING FRAUDULENT CLAIM

The claimant is liable to the United States Government for the civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages sustained by the Government. (See 31 U.S.C. 3729.)

CRIMINAL PENALTY FOR PRESENTING FRAUDULENT CLAIM OR MAKING FALSE STATEMENTS

Fine, imprisonment, or both. (See 18 U.S.C. 287, 1001.)

95-109 NSN 7540-00-634-4046 STANDARD FORM 95 PRESCRIBED BY DEPT. OF JUSTICE 28 CFR 14.2

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BY: ...

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CLAIM FOR DAMAGE, INJURY, OR DEATH	INSTRUCTIONS: Please read carefully the instructions on the reverse side and supply information requested on both sides of this form. Use additional sheet(s) if necessary. See reverse side for additional instructions.	FORM APPROVED OMB NO. 1105-0008

1. Submit To Appropriate Federal Agency:
DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF REGIONAL COUNSEL
VA PITTSBURGH HEALTH CARE SYSTEM
~~[struck out]~~ 1010 Delafield Road ~~[struck out]~~
PITTSBURGH, PA ~~15200-1237~~ 15215

2. Name, Address of claimant and claimant's personal representative, if any. (See instructions on reverse.) (Number, Street, City, State and Zip Code)
THEDE MOHR HIGHHOUSE
9091 Leet Road
North East, PA 16428

3. TYPE OF EMPLOYMENT	4. DATE OF BIRTH	5. MARITAL STATUS	6. DATE AND DAY OF ACCIDENT	7. TIME (A.M. OR P.M.)
☒ MILITARY ☐ CIVILIAN	8/23/55	Separated	2/4/11 through & continuing to 1/30/12	

8. Basis of Claim (State in detail the known facts and circumstances attending the damage, injury, or death, identifying persons and property involved, the place of occurrence and the cause thereof. Use additional pages if necessary.)
(CONT'D): On January 24, 2012, Claimant, presented to the ER department for facial and jaw pain and saw Merle W. Davison, M.D., who turned over his care to Dr. Clayton Lindemuth. Dr. Davison ordered a CT of the head without contrast for a clinical history of a headache. Findings were "worrisome for aneurysm of the tip of the basilar artery." Dr. Kavita B. Sanghvi, staff physician, read the study and recommended an MR angiogram of the brain if one was not already done. Findings were conveyed to Dr. Clayton Lindemuth, who also did nothing in response to the basilar tip aneurysm or the communicating artery aneurysm. Claimant had a follow up appointment with the clinic on January 25, 2012 that was cancelled because Lydia J. Maring, CRNP was not able to see him in follow-up until the next week. Lydia J. Maring, CRNP acknowledged receipt of the ER visit and notes but still did nothing about the abnormal results on the CT scans from 1/22/11, the CT scan from 1/24/12 and the MRA on 2/4/11. Despite several follow up visits with the VAMC and several opportunities to do so, ~~so~~ From 2/4/11 until 1/30/12 →

9. PROPERTY DAMAGE

NAME AND ADDRESS OF OWNER, IF OTHER THAN CLAIMANT (Number, Street, City, State, and Zip Code).

BRIEFLY DESCRIBE THE PROPERTY, NATURE AND EXTENT OF DAMAGE AND THE LOCATION WHERE PROPERTY MAY BE INSPECTED. (See instructions on reverse side.)

10. PERSONAL INJURY/WRONGFUL DEATH

STATE NATURE AND EXTENT OF EACH INJURY OR CAUSE OF DEATH, WHICH FORMS THE BASIS OF THE CLAIM. IF OTHER THAN CLAIMANT, STATE NAME OF INJURED PERSON OR DECEDENT.

11. WITNESSES

NAME	ADDRESS (Number, Street, City, State, and Zip Code)
(CONT'D):	

12. (See instructions on reverse) AMOUNT OF CLAIM (in dollars)

12a. PROPERTY DAMAGE	12b. PERSONAL INJURY	12c. WRONGFUL DEATH	12d. TOTAL (Failure to specify may cause forfeiture of your rights.)
N/A	$2,000,000.00	N/A	$2,000,000.00

I CERTIFY THAT THE AMOUNT OF CLAIM COVERS ONLY DAMAGES AND INJURIES CAUSED BY THE INCIDENT ABOVE AND AGREE TO ACCEPT SAID AMOUNT IN FULL SATISFACTION AND FINAL SETTLEMENT OF THIS CLAIM

13a. SIGNATURE OF CLAIMANT (See instructions on reverse side.) PA ID: 86841	13b. Phone number of person signing form	14. DATE OF SIGNATURE
[signature] Christina Shaffer, Esq. Ohio ID: 0063434	(814) 4645725 (814) 454-4540	4/25/2013

CIVIL PENALTY FOR PRESENTING FRAUDULENT CLAIM	CRIMINAL PENALTY FOR PRESENTING FRAUDULENT CLAIM OR MAKING FALSE STATEMENTS
The claimant is liable to the United States Government for the civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages sustained by the Government. (See 31 U.S.C. 3729.)	Fine, imprisonment, or both. (See 18 U.S.C. 287, 1001.)

95-109 NSN 7540-00-634-4046 STANDARD FORM 95
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MAY 0 1 2013

BY: [initials]

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CLAIM FOR DAMAGE, INJURY, OR DEATH	INSTRUCTIONS: Please read carefully the instructions on the reverse side and supply information requested on both sides of this form. Use additional sheet(s) if necessary. See reverse side for additional instructions.	FORM APPROVED OMB NO. 1105-0008

1. Submit To Appropriate Federal Agency:

DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF REGIONAL COUNSEL
VA PITTSBURGH HEALTH CARE SYSTEM
~~7180 HIGHLAND DRIVE (04A-H)~~ 1010 Delafield Road
PITTSBURGH, PA ~~15206-1297~~ 15215

2. Name, Address of claimant and claimant's personal representative, if any. (See instructions on reverse.) (Number, Street, City, State and Zip Code)
THEODE MOHR HIGHHOUSE
9091 Leet Road
North East, PA 16428

3. TYPE OF EMPLOYMENT	4. DATE OF BIRTH	5. MARITAL STATUS	6. DATE AND DAY OF ACCIDENT	7. TIME (A.M. OR P.M.)
X MILITARY ☐ CIVILIAN	8/23/55	Separated	2/4/11 through & continuing to 1/30/12	

8. Basis of Claim (State in detail the known facts and circumstances attending the damage, injury, or death, identifying persons and property involved, the place of occurrence and the cause thereof. Use additional pages if necessary.)

(CONT'D): no agent, servant or employee of the VAMC did anything in response to Claimant's basilar tip aneurysm or the communicating artery aneurysm. Even as late a week before his aneurysm ruptured, Claimant came to see his PCP as instructed but was told he needed to call to make an appt. Lydia J. Maring, CRNP acknowledged receipt of this encounter and despite another opportunity and the obligation to review his ER records and CT results of 1/24/12, did nothing in follow up for his abnormal brain test results.On January 30, 2012, Claimant complained of a headache, photosensitivity, nausea and vomiting and presented to the ER of the Erie, PA VAMC. A CT of the head showed an acute subarachnoid hemorrhage related to the anureysm of the basilar tip. His basilar tip aneurysm had ruptured and Claimant was then sent to the ER of Saint Vincent Health Center for further treatment. There, Claimant underwent a coil embolization of his basilar tip aneurysm. On April 17, 2012, Claimant underwent coil embolization of his second communicating artery aneurysm by

9. PROPERTY DAMAGE

NAME AND ADDRESS OF OWNER, IF OTHER THAN CLAIMANT (Number, Street, City, State, and Zip Code).

BRIEFLY DESCRIBE THE PROPERTY, NATURE AND EXTENT OF DAMAGE AND THE LOCATION WHERE PROPERTY MAY BE INSPECTED. (See instructions on reverse side.)

10. PERSONAL INJURY/WRONGFUL DEATH

STATE NATURE AND EXTENT OF EACH INJURY OR CAUSE OF DEATH, WHICH FORMS THE BASIS OF THE CLAIM. IF OTHER THAN CLAIMANT, STATE NAME OF INJURED PERSON OR DECEDENT.

11. WITNESSES

NAME	ADDRESS (Number, Street, City, State, and Zip Code)
(CONT'D):	

12. (See instructions on reverse.) AMOUNT OF CLAIM (in dollars)

12a. PROPERTY DAMAGE	12b. PERSONAL INJURY	12c. WRONGFUL DEATH	12d. TOTAL (Failure to specify may cause forfeiture of your rights.)
N/A	$2,000,000.00	N/A	$2,000,000.00

I CERTIFY THAT THE AMOUNT OF CLAIM COVERS ONLY DAMAGES AND INJURIES CAUSED BY THE INCIDENT ABOVE AND AGREE TO ACCEPT SAID AMOUNT IN FULL SATISFACTION AND FINAL SETTLEMENT OF THIS CLAIM

13a. SIGNATURE OF CLAIMANT (See instructions on reverse side.)	13b. Phone number of person signing form	14. DATE OF SIGNATURE
[signature] Christa S. Nacy, Esq.	(814) 464-5725 814 451-1540	4/25/2013

CIVIL PENALTY FOR PRESENTING FRAUDULENT CLAIM	CRIMINAL PENALTY FOR PRESENTING FRAUDULENT CLAIM OR MAKING FALSE STATEMENTS
PA ID: 86841 Ohio ID: 0063434 The claimant is liable to the United States Government for the civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages sustained by the Government. (See 31 U.S.C. 3729.)	Fine, imprisonment, or both. (See 18 U.S.C. 287, 1001.)

95-109 NSN 7540-00-634-4046 STANDARD FORM 95 PRESCRIBED BY DEPT. OF JUSTICE 28 CFR 14.2

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BY: [initials]

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PAGE 6 of 8

CLAIM FOR DAMAGE, INJURY, OR DEATH	INSTRUCTIONS: Please read carefully the instructions on the reverse side and supply information requested on both sides of this form. Use additional sheet(s) if necessary. See reverse side for additional instructions.	FORM APPROVED OMB NO. 1105-0008

1. Submit To Appropriate Federal Agency:	2. Name, Address of claimant and claimant's personal representative, if any. (See instructions on reverse.) (Number, Street, City, State and Zip Code)
DEPARTMENT OF VETERANS AFFAIRS OFFICE OF REGIONAL COUNSEL ~~VA~~ PITTSBURGH HEALTH CARE SYSTEM ~~7180 HIGHLAND DRIVE (646/02-H)~~ 1010 Delafield Road PITTSBURGH, PA ~~15206-1297~~ 15215	THEDE MOHR HIGHHOUSE 9091 Leet Road North East, PA 16428

3. TYPE OF EMPLOYMENT	4. DATE OF BIRTH	5. MARITAL STATUS	6. DATE AND DAY OF ACCIDENT	7. TIME (A.M. OR P.M.)
X MILITARY ☐ CIVILIAN	8/23/55	Separated	2/4/11 through & continuing to 1/30/12	

8. Basis of Claim (State in detail the known facts and circumstances attending the damage, injury, or death, identifying persons and property involved, the place of occurrence and the cause thereof. Use additional pages if necessary.)

(CONT'D):Dr. Charles Romero. Claimant continued to follow with Dr. Romero as an outpatient and continued to undergo testing, including follow-up MRIs and MRAs of the brain. On March 19, 2013, on an MRI/MRA of the brain, there was evidence of recurrence and recanalization of the previously treated basilar tip aneurysm. Claimant needs surgical retreatment of his ~~ruptured~~ recanalized basilar tip aneurysm. He is at increased risk for future harm and damages. From the time of the abnormal results of the MRA of 2/4/11 forward, and continuing until the time Claimant's basilar tip aneurysm ruptured, Lydia J. Maring, CRNP and agents, servants and employees of the VAMC were negligent each and every day Claimant's aneurysms went untreated for admittedly failing to failing to follow up on abnormal test results, failing to refer Claimant to a neurologist or other specialist for surgical treatment of his two aneurysms, failing to inform Claimant of his MRI/ MRA results from 2011 and 2012 before his basilar tip aneurysm ruptured, and doing nothing in response to three abnormal brain test results, and for

9. PROPERTY DAMAGE

NAME AND ADDRESS OF OWNER, IF OTHER THAN CLAIMANT (Number, Street, City, State, and Zip Code).

BRIEFLY DESCRIBE THE PROPERTY, NATURE AND EXTENT OF DAMAGE AND THE LOCATION WHERE PROPERTY MAY BE INSPECTED. (See instructions on reverse side.)

10. PERSONAL INJURY/WRONGFUL DEATH

STATE NATURE AND EXTENT OF EACH INJURY OR CAUSE OF DEATH, WHICH FORMS THE BASIS OF THE CLAIM. IF OTHER THAN CLAIMANT, STATE NAME OF INJURED PERSON OR DECEDENT.

11. WITNESSES

NAME	ADDRESS (Number, Street, City, State, and Zip Code)
(CONT'D):	

12. (See instructions on reverse.) AMOUNT OF CLAIM (in dollars)

12a. PROPERTY DAMAGE	12b. PERSONAL INJURY	12c. WRONGFUL DEATH	12d. TOTAL (Failure to specify may cause forfeiture of your rights.)
N/A	$2,000,000.00	N/A	$2,000,000.00

I CERTIFY THAT THE AMOUNT OF CLAIM COVERS ONLY DAMAGES AND INJURIES CAUSED BY THE INCIDENT ABOVE AND AGREE TO ACCEPT SAID AMOUNT IN FULL SATISFACTION AND FINAL SETTLEMENT OF THIS CLAIM

13a. SIGNATURE OF CLAIMANT (See instructions on reverse side.) PA ID: 86841	13b. Phone number of person signing form	14. DATE OF SIGNATURE
Thede Highhouse [signature] Esq.	(814) 464-5725 (814) 451-1540	4/25/2013

CIVIL PENALTY FOR PRESENTING FRAUDULENT CLAIM Ohio ID: 0063431	CRIMINAL PENALTY FOR PRESENTING FRAUDULENT CLAIM OR MAKING FALSE STATEMENTS
The claimant is liable to the United States Government for the civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages sustained by the Government. (See 31 U.S.C. 3729.)	Fine, imprisonment, or both. (See 18 U.S.C. 287, 1001.)

95-109 NSN 7540-00-634-4046 STANDARD FORM 95 PRESCRIBED BY DEPT. OF JUSTICE 28 CFR 14.2

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BY: [signature]

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CLAIM FOR DAMAGE, INJURY, OR DEATH	INSTRUCTIONS: Please read carefully the instructions on the reverse side and supply information requested on both sides of this form. Use additional sheet(s) if necessary. See reverse side for additional instructions.	FORM APPROVED OMB NO. 1105-0008

1. Submit To Appropriate Federal Agency:	2. Name, Address of claimant and claimant's personal representative, if any. (See instructions on reverse.) (Number, Street, City, State and Zip Code)
DEPARTMENT OF VETERANS AFFAIRS OFFICE OF REGIONAL COUNSEL VA PITTSBURGH HEALTH CARE SYSTEM ~~7180 HIGHLAND DRIVE (646/02-H)~~ 1010 Delafield Road PITTSBURGH, PA ~~15206-1297~~ 15215	THEDE MOHR HIGHHOUSE 9091 Leet Road North East, PA 16428

3. TYPE OF EMPLOYMENT	4. DATE OF BIRTH	5. MARITAL STATUS	6. DATE AND DAY OF ACCIDENT	7. TIME (A.M. OR P.M.)
☒ MILITARY ☐ CIVILIAN	8/23/55	Separated	2/4/11 through & continuing to 1/30/12	

8. Basis of Claim (State in detail the known facts and circumstances attending the damage, injury, or death, identifying persons and property involved, the place of occurrence and the cause thereof. Use additional pages if necessary.)

(CONT'D): otherwise failing to prevent subarachnoid hemorrhage and aneurysm growth in size and rupture, and were otherwise negligent in their treatment of Claimant. As a direct and proximate result of the negligence of Lydia Maring, CRNP, those under her or the Erie VAMC's control or supervision, and those responsible for supervising her, and other agents, servants or employees of the VAMC, to include Dr. Clayton Lindemuth, Dr. Maria W. Davison, David M. Lavin, M.D, and any any other agent of the VAMC, the claimant suffered injuries to his brain, a major brain bleed, injury to his heart and kidneys, and several life threatening conditions and symptoms, several surgeries and unnecessary hospital admissions and several unnecessary procedures and pain and suffering that otherwise would have been avoided. Claimant was totally disabled and has been unable to work since his aneurysm ruptured. He was and is still at least partially disabled and will remain so for the remainder of his life. He uses a cane and has lost short term memory and his ability to concentrate.

9. PROPERTY DAMAGE

NAME AND ADDRESS OF OWNER, IF OTHER THAN CLAIMANT (Number, Street, City, State, and Zip Code).

He remains under the care of specialists including neurologists and neurosurgeons as well as the VAMC to manage his resultant conditions.

BRIEFLY DESCRIBE THE PROPERTY, NATURE AND EXTENT OF DAMAGE AND THE LOCATION WHERE PROPERTY MAY BE INSPECTED. (See instructions on reverse side.)

10. PERSONAL INJURY/WRONGFUL DEATH

STATE NATURE AND EXTENT OF EACH INJURY OR CAUSE OF DEATH, WHICH FORMS THE BASIS OF THE CLAIM. IF OTHER THAN CLAIMANT, STATE NAME OF INJURED PERSON OR DECEDENT.

11. WITNESSES

NAME	ADDRESS (Number, Street, City, State, and Zip Code)

12. (See instructions on reverse.) AMOUNT OF CLAIM (in dollars)

12a. PROPERTY DAMAGE	12b. PERSONAL INJURY	12c. WRONGFUL DEATH	12d. TOTAL (Failure to specify may cause forfeiture of your rights.)
N/A	$2,000,000.00	N/A	$2,000,000.00

I CERTIFY THAT THE AMOUNT OF CLAIM COVERS ONLY DAMAGES AND INJURIES CAUSED BY THE INCIDENT ABOVE AND AGREE TO ACCEPT SAID AMOUNT IN FULL SATISFACTION AND FINAL SETTLEMENT OF THIS CLAIM

13a. SIGNATURE OF CLAIMANT (See instructions on reverse side.) PA ID: 86841	13b. Phone number of person signing form	14. DATE OF SIGNATURE
Thede Highhouse Christa Snacopolis Esq.	(814) 464-5725 (814) 454-4540	4/25/2013

CIVIL PENALTY FOR PRESENTING FRAUDULENT CLAIM Ohio ID: 0063434	CRIMINAL PENALTY FOR PRESENTING FRAUDULENT CLAIM OR MAKING FALSE STATEMENTS
The claimant is liable to the United States Government for the civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages sustained by the Government. (See 31 U.S.C. 3729.)	Fine, imprisonment, or both. (See 18 U.S.C. 287, 1001.)

95-109 NSN 7540-00-634-4046 STANDARD FORM 95 PRESCRIBED BY DEPT. OF JUSTICE 28 CFR 14.2

MAY 0 1 2013

BY: [signature]

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INSURANCE COVERAGE

In order that subrogation claims may be adjudicated, it is essential that the claimant provide the following information regarding the insurance coverage of his vehicle or property.

15. Do you carry accident insurance? ☐ Yes If yes, give name and address of insurance company (Number, Street, City, State, and Zip Code) and policy number. ☒ No

16. Have you filed a claim on your insurance carrier in this instance, and if so, is it full coverage or deductible? ☐ Yes ☒ No

17. If deductible, state amount.

18. If a claim has been filed with your carrier, what action has your insurer taken or proposed to take with reference to your claim? (It is necessary that you ascertain these facts.)

N/A

19. Do you carry public liability and property damage insurance? ☐ Yes If yes, give name and address of insurance carrier (Number, Street, City, State, and Zip Code). ☒ No

(other than Homeowner's Insurance)

INSTRUCTIONS

Claims presented under the Federal Tort Claims Act should be submitted directly to the "appropriate Federal agency" whose employee(s) was involved in the incident. If the incident involves more than one claimant, each claimant should submit a separate claim form.

Complete all items - Insert the word NONE where applicable.

A CLAIM SHALL BE DEEMED TO HAVE BEEN PRESENTED WHEN A FEDERAL AGENCY RECEIVES FROM A CLAIMANT, HIS DULY AUTHORIZED AGENT, OR LEGAL REPRESENTATIVE, AN EXECUTED STANDARD FORM 95 OR OTHER WRITTEN NOTIFICATION OF AN INCIDENT, ACCOMPANIED BY A CLAIM FOR MONEY DAMAGES IN A SUM CERTAIN FOR INJURY TO OR LOSS OF PROPERTY, PERSONAL INJURY, OR DEATH ALLEGED TO HAVE OCCURRED BY REASON OF THE INCIDENT. THE CLAIM MUST BE PRESENTED TO THE APPROPRIATE FEDERAL AGENCY WITHIN TWO YEARS AFTER THE CLAIM ACCRUES.

Failure to completely execute this form or to supply the requested material within two years from the date the claim accrued may render your claim invalid. A claim is deemed presented when it is received by the appropriate agency, not when it is mailed.

If instruction is needed in completing this form, the agency listed in item #1 on the reverse side may be contacted. Complete regulations pertaining to claims asserted under the Federal Tort Claims Act can be found in Title 28, Code of Federal Regulations, Part 14. Many agencies have published supplementing regulations. If more than one agency is involved, please state each agency.

The claim may be filed by a duly authorized agent or other legal representative, provided evidence satisfactory to the Government is submitted with the claim establishing express authority to act for the claimant. A claim presented by an agent or legal representative must be presented in the name of the claimant. If the claim is signed by the agent or legal representative, it must show the title or legal capacity of the person signing and be accompanied by evidence of his/her authority to present a claim on behalf of the claimant as agent, executor, administrator, parent, guardian or other representative.

If claimant intends to file for both personal injury and property damage, the amount for each must be shown in item #12 of this form.

The amount claimed should be substantiated by competent evidence as follows:

(a) In support of the claim for personal injury or death, the claimant should submit a written report by the attending physician, showing the nature and extent of injury, the nature and extent of treatment, the degree of permanent disability, if any, the prognosis, and the period of hospitalization, or incapacitation, attaching itemized bills for medical, hospital, or burial expenses actually incurred.

(b) In support of claims for damage to property, which has been or can be economically repaired, the claimant should submit at least two itemized signed statements or estimates by reliable, disinterested concerns, or, if payment has been made, the itemized signed receipts evidencing payment.

(c) In support of claims for damage to property which is not economically repairable, or if the property is lost or destroyed, the claimant should submit statements as to the original cost of the property, the date of purchase, and the value of the property, both before and after the accident. Such statements should be by disinterested competent persons, preferably reputable dealers or officials familiar with the type of property damaged, or by two or more competitive bidders, and should be certified as being just and correct.

(d) Failure to specify a sum certain will render your claim invalid and may result in forfeiture of your rights.

PRIVACY ACT NOTICE

This Notice is provided in accordance with the Privacy Act, 5 U.S.C. 552a(e)(3), and concerns the information requested in the letter to which this Notice is attached.

A. *Authority:* The requested information is solicited pursuant to one or more of the following: 5 U.S.C. 301, 28 U.S.C. 501 et seq., 28 U.S.C. 2671 et seq., 28 C.F.R. Part 14.

B. *Principal Purpose:* The information requested is to be used in evaluating claims.

C. *Routine Use:* See the Notices of Systems of Records for the agency to whom you are submitting this form for this information.

D. *Effect of Failure to Respond:* Disclosure is voluntary. However, failure to supply the requested information or to execute the form may render your claim "invalid".

PAPERWORK REDUCTION ACT NOTICE

This notice is solely for the purpose of the Paperwork Reduction Act, 44 U.S.C. 3501. Public reporting burden for this collection of information is estimated to average 6 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Director, Torts Branch, Attention: Paperwork Reduction Staff, Civil Division, U.S. Department of Justice, Washington, D.C. 20530 or to the Office of Management and Budget. Do not mail completed form(s) to these addresses.

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